Policy:

Mid-Missouri Supported Living, LLC, Direct Care Staff are to follow ALL STEPS of the Level 1 Medication Administration process to ensure accurate and safe medication administration.

Comments:

All Direct Care Staff are required to complete and pass the 16-hour Level I Medication Aide certification/bi-annual 4-hour refresher BEFORE administering any medications. Mid-Missouri Supported Living, LLC, staff will support individuals in administering their own medications when this process is outlined in the ISP and has been established as safe and appropriate.

A Medication Administration Record (MAR) will be used in all Mid-Missouri Supported Living, LLC, homes to track administration of medications to individuals receiving supports. This Medication Administration Record may be electronic or hard copy/paper.

Medications are only kept locked in a home if there is a safety reason to do so for any individual in the home. When there is a safety concern for one individual, ALL medications are to be kept locked in the home and staff are not to bring in their own medications unless there is a place to keep them locked. Medications are kept away from chemicals and cleaning supplies, and away from excessive heat/cold, unless intended to be refrigerated, in which case it is refrigerated. Non-oral medications must be kept separate from oral medications.

Day Program sites are required to have all medications in a locked room or cabinet.

Schedule 2 Controlled substances are to be kept double locked, counted, and recorded on Controlled Count Sheet at each shift change, or daily where there is no shift change. Schedule 3, 4, & 5 medications are kept in the same manner as other medications according to the safety needs of individuals in the home. Outgoing staff can (and should) begin counts prior to arrival of next staff and write down and sign off on their count. Incoming staff should sit down and look at outgoing staff's numbers, confirm by looking at the cards, then keys exchange hands once agreement is settled.

Only medications with a doctor's order in place, including over-the-counter medications, will be administered. Information on medication profiles/side effects is kept in the home of the individual and all staff are knowledgeable of where the information is. The pharmacy that provides medications for the individual is a back-up resource to information kept in the home, and the Community RN if there are concerns about medication side effects. Community RN is notified of any concerns regarding medication side effects and/or efficacy.

All individuals will have new and renewed prescribed medications and treatments available to the same degree of access as individuals who do not receive Home and Community Based Supports.

Medication Administration: Required Procedure
ALL Staff that administer medications in any type of home are to follow ALL STEPS of this procedure to ensure accurate and safe medication administration.

1. Only handle one individual's medications at a time.
2. Wash hands before handling medications.
3. Assemble all equipment needed.
4. Organize medications for one individual in the order of administration listed on the MAR (for bubble packs or pill bottles). Confirm medication name, time of administration, dose, etc.
5. Check each medication again against the MAR as medication is popped/removed into cup/planner/etc. to prepare for administration.
6. When all medications are popped/added, count them, and check them against the MAR and labels again.
7. Complete entire process in order for each individual meds are being administered for, one at a time.
8. Talk to the individual as you approach them and verbalize that you have their medications, identify them by name and ensure that they know who you are.
9. Hand the medication to the individual, with water if needed, and remain with the individual until the medication is swallowed.
10. Wash hands, then go to the next individual if applicable.
11. Return all equipment to storage area, washing/sanitizing as needed.
12. Record/report essential information on the MAR.

Sending Medications for Home Visits

There are three choices:

1. Send an original packaged container from pharmacy that includes dosing instructions.
2. Fill a pill planner and send copy of MAR along with it, or
3. Send pill envelopes, marked with date/time/names/doses for each administration that will be needed.

MAR Completion-Situations

EVERY staff who administers medication needs to print, sign, and initial on the back of the MAR. Only use black ink on the MAR, if hard copy mars are used.

The electronic medical record should be utilized unless extenuating circumstances do not allow for access or use. Please contact your manager for details on this issue.

1. Home Visits

For Hard Copy MARS, Mark "H" for Home Visit in the space you would usually initial after administration when the individual is on a home visit. On the back of the MAR, indicate the date range the individual was home.

For Electronic Medical Records- "LOA" is used to document this situation.

2. *Other Absences*
   For hard copy MARS- Mark "O" in the space you would usually initial after administration. On the back of the MAR, indicate where they were instead and that meds were packed (i.e. Camp Wonderland, etc.).
   In the Electronic Medical Record the following levels of documentation may be used: Administered, Missed, Refused, LOA, on Hold or Deleted. Please use these appropriate codes for administration.

3. *Medication Errors*
   If a medication or treatment is not administered to an individual (outside the window for administration or if a medication error occurs) the RN on call should be contacted and initiation of a medication error report completed. An "O" should be written in the box of the dose missed and an explanation included on the back of the MAR. Administration must also be contacted to submit a Medication Error report to CMRO/DMH.

   "Missed" should be documented in an electronic medical record MAR.

4. *Mistakes on the MAR*
   Draw one, single line through the mistake. Write error along with your initials and the date. Unless the mistake reaches the person (prevents them from getting medication), no medication error report is needed.

Prevention of Medication Errors

1. Take your time when passing medications. Reduce distractions as much as possible. Explain that this is important, you want to make sure the individual is safe, and ask them to be patient with you and wait for your attention until you are done.
2. If popping meds out of a bubble pack, make sure the med goes where you are aiming and does not get stuck somewhere.
3. Only do ONE individual's medications at a time to avoid giving the wrong med to the wrong person.
4. Know how many pills get passed for each administration for each person and count them as an extra check.
5. Always check the MAR and bubble pack 3 TIMES before administering medications.
6. Stay with the individual and watch them take their medication.
7. Never sign off on the MAR until after you know the individual took the medication.
8. Watch how much medication is left. IF you are not responsible for re-ordering, etc. notify whoever is when there is ONE WEEK left.
9. When getting medications from the pharmacy, check the order and make sure everything was received.
10. Set a timer/alarm if remembering medication times is a problem.

Disposal of Medications

1. Notify Administration/Community RN when there is medication to be destroyed (discontinued, dropped, etc.). Never flush medication down the toilet.

2. Community RN and Witness will dispose of medication together.
3. Pills are taken out of original containers.
4. They are mixed with undesirable substances (such as coffee grounds/water/cat litter) in a sealable, plastic container that is put in the trash.
5. All personal information is removed from storage containers, storage containers go in recycle or trash, and labels are destroyed to protect confidential information.

Self-Administration

All individuals will be offered the opportunity to learn and practice self-administration of their medication with staff oversight. Every individual that desires to self-administer their medications by learning each medication, what the medication is for, possible side effects, time of administration, route of administration, and possibly even the level 1 medication administration class, etc. The individual will also be able to administer their medications with staff supervision until the team including the individual and guardian/decision maker (if applicable) deem it unnecessary.

Medication Refusals

Individuals supported have the right to refuse their medications. In the event that an individual does refuse to take their medication the staff person should:

(1) Talk to the individual about the reason for the refusal to find the reason for the refusal.
(2) Offer the medication(s) several times through the "hour before and hour after" scheduled time frame that the medication may be given.
(3) Educate the individual supported on the reason for each medication and the expected outcome from taking the medication.
(4) Contact the home manager and/or Degreed Professional Manager for every medication refusal. The house manager or DPM may be able to give suggestions of techniques that have worked in the past regarding refusals.
(5) All medication refusals will need to be listed on the MAR as a medication refusal.

The Home manager and/or DPM will need to contact the Agency RN to discuss the medication refusal and the RN will advise the home manger or DPM on whether to notify the doctor immediately, set up a physician appointment to discuss the medication refusal or what the next steps should be.

Approved by: _____

Robert Palmer, RN, BSN, Owner MMSL